Forms to Copy

The following forms can be copied and used by the provider as needed:

- Accommodation and Room Rates Schedule
- Adjustment Request Form (with instructions)
- (AND) Administratively Necessary Day Intake Form
- Authorization for Electronic Funds Transfer
- Certificate of Medical Necessity (CMS 484, with instructions)
- Change of Provider Information Authorization Form
- Crisis Authorization Worksheet (Care Management Bureau)
- Compound Drug Form
- Dental Prior Authorization Form – General
- Dental Prior Authorization Form – Orthodontics
- Durable Medical Equipment/Supplies Request Form
- Electronic Claims Submission Certification and Authorization
- Electronic PA Request Attachment Cover Sheet
- Group Affiliation Roster
- Hospice Intake Form
- Individual Affiliation Roster
- Medical Necessity Form (pregnancy related)
- NDC Detail Attachment
- Personal Care Services Progress Notes (with instructions)
- PET Scan Prior Authorization Intake Form
- Request for Additional Crisis Case Management Hours
- Request for Taxpayer Identification Number and Certification (W-9)
- Signature-on-File Form
- Surgery Prior Authorization Request
- Transportation Request (with instructions)
- Vision Prior Authorization Request

To print a form, select print from the Acrobat Reader tool bar and select "current page" or enter the page range.

Forms to Order from EDS

The following forms can be ordered from EDS. See the next page for ordering instructions.

Drug Claim Form	352-023
Finger Print Card	FD258
Notice of Admit or Discharge: NF or ICF/MR	HW0458
PASARR Screen Form	HW0087
PCS Assessment and Care Plan	RMU 14.01
Physicians Medical Care Evaluation for PCS	HW0603 3/98
QMRP Assessment	HW0615
QMRP Visit	HW0621
Self Declaration for Criminal History	HW0284
Sterilization Consent Form	HW0034
Visit Notes for Supervising Nurses	HW0620

Order Form Instructions

Use this form to order any of the forms listed from EDS.

- Copy this page as needed.
- Enter your provider name and Idaho Medicaid number
- Enter the quantity needed
- Complete the 'Send to' section. This will be used as the mailing label for your order. Please print.
- Indicate if the materials should be sent to the attention of a person or department.
- After completing the order form, mail it to:

  EDS
  P.O. Box 23
  Boise, ID 83707

Forms can also be ordered by phone. Call MAVIS at (800) 685-3757. Ask for *AGENT.*

Provider Name: _____

Idaho Medicaid Provider Number: _____

	Form Name	Form Number	Quantity
☐	Drug Claim Form	352-023	_____
☐	Finger Print Card	FD258	_____
☐	Notice of Admit or Discharge: NF or ICF/MR	HW0458	_____
☐	PASARR Screen Form	HW0087	_____
☐	PCS Assessment and Care Plan	RMU 14.01	_____
☐	Physicians Medical Care Evaluation for PCS	HW0603 3/98	_____
☐	QMRP Assessment	HW0615	_____
☐	QMRP Visit	HW0621	_____
☐	Self Declaration for Criminal History	HW0284	_____
☐	Sterilization Consent Form	HW0034	_____
☐	Visit Notes for Supervising Nurses	HW0620	_____

From: EDS
P.O. Box 23
Boise, ID 83707

Send to: _____

_____

_____

_____

Attention: _____

Name of Institution _____

Idaho Medicaid Provider Number _____ Total number of licensed hospital beds _____

Enter the usual and customary rate and the effective date for each applicable accommodation revenue code. Only the codes listed may be updated. This schedule is not required for Dialysis Units.

Authorized Signature _____ Date _____

Name printed or typed: _____

Return to: EDS
Provider Enrollment **Fax: (208) 395-2198**
PO Box 23
Boise, ID 83707

Revenue Code	Accommodations	Rate	Effective Date
101	All Inclusive Room/Board		
111	Medical / Surgical / GYN		
112	Obstetric		
113	Pediatric		
114	Psychiatric		
116	Detoxification		
117	Oncology		
118	Rehabilitation		
120	Semi-Private		
121	Medical / Surgical / GYN		
122	Obstetric		
123	Pediatric		
124	Psychiatric		
126	Detoxification		
127	Oncology		
128	Rehabilitation		
130	Semi-Private		
131	Medical / Surgical / GYN		
132	Obstetric		
133	Pediatric		
134	Psychiatric		
136	Detoxification		
137	Oncology		
138	Rehabilitation		
140	Private		

Revenue Code	Accommodations	Rate	Effective Date
141	Medical / Surgical / GYN		
142	Obstetric		
143	Pediatric		
144	Psychiatric		
146	Detoxification		
147	Oncology		
148	Rehabilitation		
150	Room and Board - Ward		
151	Medical / Surgical / GYN		
152	Obstetric		
153	Pediatric		
154	Psychiatric		
156	Detoxification		
157	Oncology		
158	Rehabilitation		
164	Sterile Environment		
170	Nursery		
171	Newborn		
172	Premature		
173	Neo-Natal Intensive Care Level III		
174	Neo-Natal Intensive Care Level IV		
200	Intensive Care Unit		
201	Surgical		
202	Medical		
203	Pediatrics		
204	Psychiatric		
207	Burn Care		
208	Trauma		
210	Coronary Care Unit		
211	Myocardial Infarction		
212	Pulmonary Care		
213	Heart Transplant		

Mail to: EDS
PO Box 23
Boise, ID 83707

Do not fax this form

Information: (800) 685-3757

Adjustment Request Form

1. Provider Medicaid Number: _____

2. Prov. Name: _____

3. Prov. Address: _____

_____ ZIP _____

4. Claim ICN: _____

5. Client Medicaid Number: _____

6.Client Name: _____

7. RA Number: _____

8. RA Date: _____

9. Correct Billing Information:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment

10. Requested Action:

☐ I am refunding the overpayment (attach check made out to: **State of Idaho**).

☐ Please withhold overpayment in a future Medicaid warrant with an adjustment.

☐ Please pay me more in a future warrant due to an underpayment by Medicaid.

11. Signature: _____ Date: _____

EDS use only Related History ICN: _____

Action: _____

Adjustment Request Form Instructions

This Adjustment Request Form can be duplicated for use as needed. When making copies, it is not necessary to copy these instructions also. Adjustment requests must be mailed. Please do **not** fax this form.

1. Provider Medicaid Number: enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your remittance advice (RA).

2. Prov. Name: enter your provider name. This is in the lower right-hand corner of the first page of your RA.

3. Prov. Address: enter your mailing address. This is in the lower right-hand corner of the first page of your RA.

4. Claim ICN: This is the unique 15-digit claim identification number. It is found on the Paid Claim page of your RA following the client's MID.

5. Client Medicaid Number (MID): enter the 7-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.

6. Client Name: enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.

7. RA Number: This is in the upper right-hand corner of the first page of your RA.

8. RA Date: enter the date from the RA. This is at the top of the first page of your RA.

9. Correct Billing Information: simply and clearly state what the correct billing information should have been on the claim. If a line of a claim needs to be corrected, enter the line number from the claim form. Enter what was wrong on the line and the correct information to replace it.

   Example: a claim is incorrectly billed with 100 units on line 4 and, after the claim is submitted, the provider receives a check from other insurance. The correct number of units is 10 and the insurance amount is $1124.47. Complete the form as shown:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment
4	*100 units billed*	*Correct number of units is 10*
		Other insurance paid $1124.47

10. Requested Action: select the appropriate box. If you owe a refund to Medicaid because of an overpayment, you can send a check for the amount or request that the overpayment be deducted from future warrants. Make checks payable to: **State of Idaho**.

11. Signature: the person who completes this form must sign and date it.

Adjustments may be initiated by:

- Providers to correct claims submission or processing errors
- EDS to recoup incorrect payments
- DHW for recoupments or retroactive rate adjustments

Adjusted claims are grouped together in the RA by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and a total net adjustment amount is calculated to reflect the net effect of all adjustments.

(AND) ADMINISTRATIVELY NECESSARY DAY INTAKE FORM

FAX TO: Idaho Medicaid Care Management

(208) 364-1864

Date	
Requesting Agency Name	
Contact Person	
Phone #	
Fax #	
Address	
Hospital Medicaid Provider #	
Attending Physician	
Hospital admission date	
Patient Name	
Medicaid #	
Diagnosis	
ICD-9 Codes	
Reason for AND Request	
AND Dates requested	
Supporting Documents Required – please attach the following	☐ Summary of patient's medical condition ☐ Current History and Physical ☐ Physician progress notes ☐ Statement as to why patient can not receive necessary medical services in a non-hospital setting □ ☐ Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services □
MEDICAID USE ONLY	
# of AND Approved	
Dates Approved	
Authorization #	
Request Denied	
Reason Denied	
Log Completed by Staff Signature	

Authorization for Electronic Funds Transfer

Complete all the sections below **if** you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: you must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provider below. (Please, do **not** staple the check.)

Provider Name	
Bank Name	**Bank Phone Number**
Bank Address	
Account Number	
Transaction Routing Number (nine digit) ___ ___ ___ ___ ___ ___ ___ ___ ___	
Type of Account (circle only one) **Checking** **Savings**	

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized signature: _____

Name typed or printed: _____

Idaho Medicaid provider number: _____

Date: _____

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

For checking account deposit only,
tape a voided check here.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODE	**PT DOB ____/____/____; Sex ____ (M/F) ; HT._____(in.) ; WT._____(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____% c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
(Y) (N)	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
(1) (2) (3)	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
(Y) (N) (D)	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "**X**".
a) _____ mm Hg b) _____% c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

(Y) (N) (D)	8. Does the patient have dependent edema due to congestive heart failure?
(Y) (N) (D)	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
(Y) (N) (D)	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. *(See instructions on back.)*

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Change of Provider Information Authorization Form

Provider Number:	**Provider Name:**
Date requested information is effective:	
Please change the information for the following name(s) or address(es): _____ Pay-to _____ Mail-to _____ Service Location(s)	
Old Name	New Name (attach a signed W-9 with effective date if Pay-To name is changing)
Old Address:	New Address:
Old Telephone Number:	New Telephone Number:
Old Tax ID Number:	New Tax ID Number: (attach a signed W-9 with effective date)
Additional Comments	
Provider Signature: **Date Signed:**	

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Department of Health and Welfare
Care Management Bureau
CRISIS AUTHORIZATION WORKSHEET

Provider Agency: **Staff Requesting:**

Consumer Name: **Date:** **Time Began:** **Time End:** **Total Time:**

SSN: **MID #** **Service at ER?** ☐ **Y** ☐ **N** **Age:** **Gender:**

Current Living Situation: (Check one)

☐ LA – Live Alone ☐ F - Live with Friends ☐ RALF- Residential Assisted Living Facility ☐ CF – Corrections Facility
☐ S- Live with Spouse ☐ SH- Shelter Home ☐ NW/CFH-Non-Waiver Certified Family Home ☐ HL – Homeless
☐ P-Lives with Parents/Stepparents ☐ FH- Foster Home ☐ W/CFH-Waiver Certified Family Home
☐ R-Live with Relatives ☐ RC- Respite Care ☐ J-Jail

Employment Status: (Check one)

☐ IE-Independent Employment ☐ NW-Non-Waiver Supported Employment ☐ UE-Unemployed ☐ Volunteer
☐ W-Waiver Supported Employment ☐ EMP/SW-Sheltered Workshops ☐ S-School

Presenting Problem:

Is substance abuse involved with the incident?

☐ Alcohol ☐ Drugs ☐ Both ☐ None

Crisis Service Provided:

Crisis Resolution Plan (Plan for intervention that resolves crisis):

Crisis Prevention Plan (What will occur to prevent future crisis):

Crisis Outcome (Follow-up within 7 days by Care Manager):

Crisis Hours Authorized:

H2011– Community Crisis Support **Number of Units** **Start Date** **End Date**

Prior Authorization #

Crisis Hours Denied:

H2011 – Community Crisis Support **Number of Units**

Explanation for Denial:

Care Manager Signature _____ **Date:** _____

Care Management Process:

1. Upon receipt the Care Manager has (3) business day hours to make a determination on the request or notify the provider of missing information.
2. When the provider receives the notification, they have (3) business day hours to submit the missing information to the Care Manager.
3. The request will be “CLOSED” if the Care Manager does not receive the identified information within (3) business day hours.
4. The Care Manager has (3) business day hours to make the determination and notify the provider.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Compound Detail NDC Attachment

This form is a required attachment for any Idaho Medicaid paper claim billed for a compound claim

PROVIDER NAME_____ PROVIDER NUMBER_____

CLIENT NAME_____ CLIENT ID NUMBER_____ DATE OF SERVICE_____

LINE	NDC	Drug Name	Quantity	UNIT OF MEASURE	Ingredient Cost	Route of Administration
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	
				GM ML EA	$	

Please fill in:

- Use NDC 00000-0000-00 on your Claim form
- The corresponding line number from the Pharmacy Claim form
- Include every NDC number used
- The drug description
- The quantity for each ingredient
- Circle the appropriate unit of measure
- The total charges for that line item
- The route of administration for the final compound product
- **If any value is left blank no payment will be made**

December 2004

Idaho Medicaid Dental Program
Dental Prior Authorization Form – General

Medicaid Client Information

Last Name:	First Name:	Initial:
Street Address:		
City:	State:	Zip Code:
Client Medicaid ID Number:	Date of Birth:	

Providing Dentist Name:		
Address:		
City:	State:	Zip Code:
Phone Number : ( )	Provider ID (Medicaid Number):	

Date of Service	Tooth	Procedure Code	Description

Remarks:

Place of Service (check the appropriate box)

☐ Office ☐ Hospital ☐ Long-Term Care Facility ☐ Ambulatory Surgical Center ☐ Other

Replacement: ☐ Yes ☐ No	**Enclosures:** ☐ Pano ☐ X-Ray ☐ Model(s)

(Department Use Only) Do not write in boxes below

Procedure(s) being authorized or denied:

Authorized: ☐	**Denied:** ☐	**Reviewer(s) Initials:**	**PA Number:**

IDAPA Reference:

Idaho Medicaid Dental Program
Dental Prior Authorization Form – Orthodontics

Medicaid Client Information

Last Name:	First Name:	Initial:
Street Address:		
City:	State:	Zip Code:
Client Medicaid Number:	Date of Birth:	

Provider Name:

Address:		
City:	State:	Zip Code:
Phone Number : ( )	Provider ID (Medicaid Number):	

Please check box to indicate if additional information is attached to the prior authorization form

Diagnostic Summary Notes ☐ - Attached

Treatment Summary Notes ☐ - Attached

Key Factors in Treatment ☐ - Attached

Probable Treatment Plan ☐ - Attached

Procedure Code(s):

Enclosures: ☐ **Pano** ☐ **X-Ray** ☐ **Model(s)**

(Department Use Only) Do not write in boxes below

Procedure(s) being authorized or denied:

Authorized: ☐	**Denied:** ☐	**Reviewer(s) Initials:**	**PA Number:**

IDAPA Reference:

IDAHO MEDICAID DME/SUPPLIES REQUEST FORM

State of Idaho
Department of Health & Welfare
Division of Medicaid
PO Box 83720
Boise, ID 83720-0036
1-866-205-7403

URGENT

YES NO

DEPARTMENTAL USE ONLY

Provider Name:

Contact Person: | **Phone: ( )** | **Fax: ( )** | **Provider Number:**

Provider Address: | **City:** | **State:** | **Zip:**

Client Name: | **Client MID:** | **DOB:**

Client Address: | **City:** | **State:** | **Zip:**

Physician Name/Address:

Insurance Information: | **Diagnosis:**

Healthy Connections Physician: | **Healthy Connections Referral #:**

DESCRIPTION	HCPCS Code	QUANTITY	START DATE	STOP DATE	PRICE	Rental/Purchase

Please attach all appropriate medical necessity and pricing documentation to support the request

FAX: 1-800-352-6044

_____, hereinafter referred to as 'Provider', hereby certifies as follows:
(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the Provider.

The Provider understands that the use of electronic claims submission does in no way relieve the Provider of responsibilities for (a) maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the Provider to Medicaid recipients, and making such records available upon request to the Department of Health and Welfare (DHW) and the United States Department of Health and Human Services; and (b) promptly returning to the Department of Health and Welfare, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The Provider certifies that the claim is due; that the Provider is authorized to sign for the payee; that complete records of these services are being kept in hardcopy form for five (5) years and will be provided upon request. The Provider accepts payment in full for the claims submitted subject to adjustment as authorized by Department regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. The Provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The Provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all Federal and State laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed Provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The Provider understands that any payments made in satisfaction of claims submitted will be derived from Federal and State funds and that any false claims, statements, or documents, or concealment of material fact may be subject to prosecution under applicable Federal and State law.

If the Provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with Federal and State laws pertaining to the Idaho Medicaid Program, as amended.

The Provider understands that the Department reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the Provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The Provider holds EDS harmless and indemnifies EDS against any liability to the Provider, the State of Idaho, or to any Medicaid Provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

DHW shall allow Providers to enter Medicaid claims through the claims entry system developed by the Department's fiscal agent and designated Electronic Claims Submission (ECS), or through the use of entry screens developed by authorized computer vendors, or by magnetic tape or cartridge.

Both EDS and the State of Idaho must approve of any provider **prior** to the submission of electronic claims.

The Provider shall allow the Department access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

Continued on page 2.

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Authorized Signature: _____ Date: _____

Name printed or typed _____

SECTION II

(To be completed by Providers using a Billing Service)

The Provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The Provider hereby certifies that _____ is authorized to
(Billing Service)
submit electronic claims on Provider's behalf.

The Provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to the Department or its fiscal agent.

Authorized Signature _____ Date _____

Name printed or typed _____

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757
Ask for Provider Enrollment

Idaho Medicaid
Electronic PA Request Attachment Cover Sheet

Complete and submit this cover sheet with the required attachment when you submit an electronic HIPAA formatted Prior Authorization Request (HIPAA 278 transaction). We will match the information on this cover sheet with your electronic PA request.

This cover sheet is not required for PAs that are not requested electronically.

Please provide the following information:

Prior Authorization Control # Note – This number must match the control number required on the PA request	
Date electronic PA request was submitted	
Provider Name	
Provider 9-digit ID Number	
Client Name	
Client's 7-digit Medicaid ID Number	
Date(s) of Service	

Group Affiliation Roster

This page is used by groups to affiliate individual Medicaid providers with the group. Providers must be enrolled as individuals **before** they can be affiliated with a group. If more space is need, copy this page and complete the listing. Listing a provider on this roster does **not** enroll the individual in the Idaho Medicaid program. Do **not** list individuals who will not be furnishing Medicaid services or who are not enrolled as Medicaid providers.

NOTE: Each provider listed on this roster must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name _____ **Group number** _____

Individual Provider Name	Idaho Medicaid Individual Provider Number	Individual Provider Signature	Date Signed	Date Effective

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

HOSPICE INTAKE FORM

FAX TO: Idaho Medicaid Care Management at (208) 364-1864

Today's Date	
REQUESTING AGENCY INFORMATION	
Hospice Contact Person	
Name of Hospice	
Hospice Idaho Medicaid Provider Number	
Address	
Phone #	
Fax #	
PATIENT INFORMATION	
Name of Patient	Date of birth:
Idaho Medicaid Number	
Address of Current Residence	
Check one of the following	☐ Skilled Nursing Facility ☐ Intermediate Care Facility for Mentally Retarded ☐ Own Home ☐ Certified Home
Date of Hospice Election	
Date of Death/Revoke	
Diagnosis	
ICD-9 Codes	
Check all of the following that apply – Patient has coverage including	☐ Medicare ☐ A&D Wavier (Aged and Disabled) ☐ DD Wavier (Developmentally Disabled) ☐ PCS (Personal Care Service) ☐ Other in-home care, specify: ☐ Healthy Connections No ☐ Yes ☐
Supporting Documents Required – please attach the following	☐ Signed Hospice Election Form ☐ Current History and Physical ☐ Physician Orders for Hospice ☐ Hospice Care Plan ☐ Healthy Connections Physician Referral Number: _____
Ordering Physician	☐ Physician is hospice agency employee ☐ Physician is hospice volunteer ☐ Physician is private practitioner

Revised: 10/07/2002

Individual Affiliation Roster

This roster is used by individual providers who wish to affiliate with a group (or groups) already enrolled in the Idaho Medicaid program. Providers must be enrolled as individuals **before** they can be affiliated with a group. Being included in a group enrollment **does not** enroll the individual with Medicaid.

Do **not** complete this page if you are an individual provider not affiliated with a group practice.

NOTE: Listing a group on this form does **not** enroll the group in the Idaho Medicaid program.

NOTE: The individual provider must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name	Idaho Medicaid Group Provider Number	Date Signed	Date Effective

I wish to be affiliated with the above listed group(s) in the Idaho Medicaid program.

Signature: _____

Name typed or printed: _____

Provider Medicaid identification number: _____

Date: _____

Mail to: EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Medical Necessity Form (pregnancy related)

Client Name:_____

Client Medicaid Identification Number: _____

Date of Service: _____

Describe How Service is Pregnancy Related:

_____

_____

_____

_____

_____

Provider signature: _____

Name typed or printed: _____

Idaho Medicaid Provider number:_____

Date: _____

Mail to: **EDS**
P.O. Box 23
Boise, ID 83707

Information: (800) 685-3757

IDAHO DEPARTMENT OF HEALTH & WELFARE

NDC Detail Attachment

This form is a required attachment for any Idaho Medicaid paper claim billed using a drug HCPCS code on a CMS-1500 or a UB-92

PROVIDER NAME_____ PROVIDER NUMBER_____

CLIENT NAME_____ CLIENT ID NUMBER_____ DATE(s) OF SERVICE_____

LINE	NDC	DESCRIPTION	UNITS	BASIS OF MEASUREMENT			TOTAL CHARGES
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$

Please fill in:

- The corresponding line number from the CMS-1500 (HCFA-1500) or the UB-92
- The NDC number used
- The drug description
- The actual quantity (units) given to the patient
- Check the appropriate basis of measurement
- The unit price for the NDC

Personal Care Services Progress Notes

PCS Provider _____ Medicaid Provider Number _____

Client Name _____ Client Medicaid Number (MID) _____

Client Address _____ Client Phone Number _____

I certify that the data on this form is accurate and correct.

Provider Signature _____ Date _____

Client Signature _____ Date _____

Date	Bath	Shampoo	Shave	Grooming/Oral care	Dressing/undressing	Bladder/bowel	Nail care	Ambulate	ROM: active/passive	Turn/position	Meal preparation	Feeding	Grocery shopping	Linen change	Laundry	Vacuum	Dust	Mop/sweep	Empty trash	Clean bathroom	Clean kitchen	Empty catheter bag	Clean BSD, leg bag	Therapy	Transportation	Supervising nurse	Other	Time in	Time out	Total hours

Date	Observations, changes, problems

Personal Care Services Progress Notes Instructions

Personal care services providers are required to supply their own forms for Personal Care Services Progress Notes. Providers may make copies of the form on the reverse side of these instructions, create their own version containing the required information pursuant to the Rules Governing Medical Assistance, IDAPA 16.03.09.146.11, or make copies of the older form Alternative Care Services HW 0609 (2/88).

A copy of the client's progress notes shall be maintained in the client's home unless authorized to be kept elsewhere by the RMS. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services.

The following instructions are for the PCS Progress Notes.

Please make copies of this form as needed. It is **not necessary** to include these instructions unless desired by the user.

Instructions

PCS Provider: enter your provider name. This is in the lower right-hand corner of the first page of your remittance advice (RA).

Provider Medicaid Number: enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your RA.

Client Name: enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.

Client Medicaid Number (MID): enter the 7-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.

Client Address: enter the address at which the Medicaid client lives.

Client Phone Number: if the client has a home telephone, enter the number.

Provider Signature/Date: the person who completes this form must sign and date it.

Client Signature/Date: the client who receives the services must sign and date this form, **unless** it is determined by the RMU that the client is unable to do so.

Indicate the date, type of service(s), time in/out, and total hours for all services provided.

Indicate the client's response to the service, including any changes noted in the client's condition. Enter any changes in the treatment plan authorized by the referring physician, other provider, supervising registered nurse, or QMRP as the result of changes in the participant's condition.

PET Scan Prior Authorization Intake Form

FAX TO: Idaho Medicaid Care Management

Fax: (208) 364-1864 Phone: (208) 364-1824

Today's Date	
Name of Requesting Agency	
Address	
Phone #	
Fax #	
Contact Person	
Agency Medicaid Provider #	
Ordering Physician	
Healthy Connections Physician and referral number (if applicable)	
Patient Name	
Medicaid #	
Diagnosis	
ICD-9 Codes	
Reason for PET Scan Request	
Type of PET Scan Requested	
HCPCS Billing Code (i.e. G-code)	
Requested Date-of-Service	
Supporting Documents ***Required*** – please attach the following	Summary of patient's medical condition □ Current History and Physical □ Previous CT Scan results (if applicable) □ Previous MRI results (if applicable) □
Medicaid Use Only	
Prior Authorization #	
Dates Approved	
Request Denied	
Reason Denied	
Log Completed by Staff Signature	

REQUEST FOR ADDITIONAL CRISIS CASE MANAGEMENT HOURS

Additional Community Crisis Case Management hours are requested in order to facilitate access to emergency community resources, by linking/coordinating, and/or advocating for services. Please complete this form and forward to Behavioral Health Care Management Unit.

Participant Name: _____ Number of Hours Requested: _____

Medicaid Number: _____ Start Date: _____ End Date: _____

From Case Manager: _____

Provider Number: _____

Participant must meet all of the following criteria:

- **Imminent risk (within 14 days) of hospitalization or institutionalization; and**
- **Experiencing symptoms of psychiatric decompensation; and**
- **Has received the maximum number of monthly hours of ongoing case management and crisis case management; and**
- **No other crisis assistance services are available under other Medicaid mental health option services (including Psychosocial Rehabilitation Services)**

Crisis must be precipitated by an unanticipated event, circumstance, or life situation that places the participant at risk of: (check all that apply)

- ☐ Hospitalization
- ☐ Losing employment or major source of income
- ☐ Incarceration
- ☐ Physical harm to self or others (family altercation or psychiatric relapse)
- ☐ Becoming homeless

Please document the following information in detail, attach the case management assessment & treatment plan, and any applicable progress notes.

---

1. Presenting Problem:

A. Date crisis began:

B. Describe the crisis, include the unanticipated event or circumstance that lead to the crisis.

C. What symptoms of psychiatric decompensation are present?

2. Crisis Response History:

MONTH TO DATE TOTALS:

Ongoing Case Management: _____ Crisis Case Management: _____

A. What linking, coordination, or advocacy services have already been provided to resolve this crisis? (Include the number of ongoing case management and crisis case management units or hours already provided during this calendar month).

B. What other crisis assistance services are available to the recipient under other Medicaid mental health option services (e.g. Psychosocial Rehabilitation Services)?

3. Crisis Resolution Plan

A. Action Plan: What is your agency's response to resolving the crisis? (Be specific and identify what linking, coordinating, or advocacy services will be provided)

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/incarceration/out of home placement?

Participant Name: _____ **Agency Name:** _____

Phone Number: _____ **Fax Number:** _____

E-Mail Address: _____

Division of Medicaid
Behavioral Health Care Management Unit
Phone 364-1903 Fax 364-1911

Central Office Care Manager
Shannon Froehlich, MS
froehlics@idhw.state.id.us

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Signature-on-File Form

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- the charges submitted for the material furnished and services rendered are correct charges against the State of Idaho pursuant to applicable Department regulations and State law;
- the claim is due;
- I am authorized to sign for the payee;
- complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services; the Idaho Department of Health and Welfare, and the Medicaid Fraud/SUR Section;
- I accept payment as payment in full subject to adjustment in accordance with the Department regulations;
- all materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from Federal and State funds and that any falsification or concealment of material fact is subject to prosecution under applicable Federal and State laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized signature: _____

Name typed or printed: _____

Idaho Medicaid provider number:_____

Date: _____

The provider or responsible corporate official must sign this certificate statement.

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
att. Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Idaho Medicaid Surgery Prior Authorization Request

To Requesting Provider: Please complete form, attach required documentation and return to address below

Prior Authorization Requesting Information

Client

Name _____ Date _____

Medicaid # _____ Proposed Surgery Date _____

Date of Birth _____ ☐ Inpatient ☐ Outpatient

Requesting Provider

Name _____

Address _____

City/Zip _____

Phone _____

Fax _____

Provider # _____

Surgeon (if different from requesting provider)

Name _____

Address _____

City/Zip _____

Phone _____

Fax _____

Provider # _____

CPT Codes and Procedure Descriptions

_____

_____

_____

_____

Comments

_____

_____

_____

_____

Please Attach

Call (208) 364-1839 for criteria related to specific surgery

Send to:

Division of Medicaid
Physician Consultant
PO Box 83720
Boise, ID 83720-0036

(208) 364-1839 Phone
(208) 364-1864 Fax

General Required Documentation (Mark all items attached)

- ☐ History and Physical
- ☐ Consultations
- ☐ Physician/Surgeon Notes
- ☐ Treatment Plans
- ☐ History of Disease
- ☐ Present Condition

For Departmental Use Only

☐ Approved ☐ Denied

- ☐ 16.03.09065.02b cosmetic surgery not covered
- ☐ 16.03.09065.02h new procedure of unproven value
- ☐ 16.03.09066 reconstruction surgery not covered
- ☐ 16.03.09069.01 surgical procedure for weight loss not met
- ☐ 16.03.09069.04 abdominoplasty/panniculectomy not met

Date of Decision _____ Date entered into system _____

Reviewer's Signature_____ Prior Authorization Number _____

Transportation Request

Date/Time Provider Phone: ( )

Region: Provider Name: Provider Fax ( )

Provider #:

Client Information	
Client MID	
Client Name	
Client DOB	
Client Phone	
Client Address	
Client City/State/Zip	
Why Not Driving Self	
Medical Services/Reason For Transport	
Client's Healthy Connections Physician (if applicable)	
Special Transport Needs? (Wheelchair Van)	
Medical Provider Information	
Medical Provider Name	
Medical Provider Phone	
Medical Provider Treatment Address	
Physician Referral Obtained (if service is outside of community)	
Transport Information	
Dates of Service	
Appointment Time	
Initial Blanket Authorization	
Blanket - Days Of The Week	
Pick-Up Address	
Drop Off Address (End of Transport)	
Total Loaded Miles Per Trip	
Services Requested	
Procedure Codes Requested	
Units Requested Per Code	
Price Per Unit	
For Medicaid Use Only	
Approved / Denied	
DB Completed	
PA Completed	

Transport Request Form Instructions

Use these instructions to complete the Transport Request Form. Complete all fields on the form.

Field Name	Description of required data
Client Information	
Client MID	Complete 7-digit client Medicaid identification number. It is the responsibility of the requestor to verify current client eligibility prior to making request
Client Name	Name as it appears on the Medicaid ID card
Client DOB	Client's date of birth.
Client Phone	Phone number where client/guardian may be reached for verification of request.
Client Address	Client's actual physical address (residence).
Client City/State/Zip	City, state, zip code for client's address.
Why Not Driving Self	Explain why the client needs state-funded transportation. For example, the client cannot drive due to age, physical disability, there is not a vehicle in the household, or other free resources available such as friends, family members, or charitable organization.
Medical Services/Reason for Transport	Provide only enough information to determine if medical service is a covered benefit. *Example*: "Counseling" is **not** adequate as there are many types of counseling that are not covered such as vocational, marital, etc.
Client's Healthy Connections Doctor (if applicable)	If client is enrolled in Healthy Connections, enter name of primary care provider.
Special Transport Needs? (Wheelchair Van)	Enter special needs for this client such as wheel chair, ambulance, etc.
Medical Provider Information	
Medical Provider Name	Actual name of the clinic or individual medical provider, if a solo practitioner.
Medical Provider Phone	Phone number where appointment can be verified.
Medical Provider Treatment Address	Address where client will be transported to.
Physician Referral Obtained If request is to transport client out of their local community to a distant provider, the following documentation is required ⇒	**From The Referring Physician:** • Diagnosis • Reason for the referral to a distant provider • Statement that equivalent services are not available locally • Brief history of the client's case **From the Distant Receiving Physician:** • Acknowledgement they have accepted this Idaho Medicaid client • Date and time of appointment • Anticipated medical services to be provided • Estimated length of treatment and follow-up visits based on the referral information received from the referring physician • Statement that the medical services to be provided are not available in the client's community or at a closer location Receiving physician understands he/she must contact the Department directly for services requiring prior authorization or extended medical care • Physician's Idaho Medicaid Provider Identification Number (9-digits)

Transport Information	
Dates of Service	From Date: 1st date of transport To Date: last date of transport. This will be the same date unless request was for a “blanket authorization” to include several dates.
Appointment Time	Time of appointment
Initial Blanket Authorization	Indicate if this is or is not a blanket request.
Blanket – Days of Week	
Pick-Up Address	Physical address where client will be picked up. May enter “home” if same as client address.
Drop Off Address (End of Transport)	May enter “home” if being returned home.
Total Loaded Miles Per Trip	
Services Requested	
Procedure Codes Requested	Enter the transportation procedure code you will be billing to Medicaid. Check *Notification of Decision* letter when received to be certain mileage and procedure code are correct PRIOR to billing.
Units Requested Per Code	1 unit = 1 mile. Enter total ROUND TRIP miles for this request. If this is a blanket request, enter TOTAL MILEAGE for the entire blanket authorization that would include all trips.
Price Per Unit	Enter the “price per unit” which should appear on the *Notice of Decision* letter calculated with rate chart.

VISION PRIOR AUTHORIZATION REQUEST

FAX TO: **STEVE BROWN**
DIVISION OF MEDICAID
(208) 364-1910

FOR DEPARTMENT USE ONLY

PA Number: _____

Reviewed by: _____

Review Date: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____ **PHONE NUMBER:** _____

CLIENT NAME: _____

MEDICAID ID: _____ **DATE OF SERVICE:** _____

==========

SERVICE REQUESTED:

HIGH INDEX LENS: _____ **ASPHERIC LENS:** _____ **POLYCARBONATE:** _____

CONTACTS: _____

OTHER:

_____

_____

PLEASE COMPLETE THE RX BELOW OR ATTACH A COPY WITH THIS REQUEST

Rx		Spherical	Cylindrical	Axis	Prism	Base
D.V.	O.D.					
	O.S.					
N.V	O.D.					
	O.S.					

JUSTIFICATION -- DIAGNOSIS -- COMMENTS:

_____

_____